

# RHODE ISLAND HEALTH CARE COST GROWTH TARGET

## IMPLEMENTATION MANUAL

July 31, 2019

Version 5

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## Overview

In 2018, Rhode Island Governor Gina Raimondo, the Executive Office of Health and Human Services (EOHHS) and the Office of the Health Insurance Commissioner (OHIC) convened the Rhode Island Health Care Cost Trends Steering Committee (Steering Committee) to develop an annual health care cost growth target (Target) for Rhode Island. The Steering Committee consisted of a broad range of stakeholders. It deliberated the methodology of a cost growth target and how to measure its performance, and formalized its recommendations through a voluntary compact signed by all Steering Committee members in December 2018. Governor Raimondo affirmed the cost growth target and her administration's commitment to assessing and reporting on performance relative to the target in Executive Order 19-03, issued February 6, 2019.

This implementation manual contains the technical and operational steps that the State will need to take to implement the health care cost growth target. This manual contains the methodology the Steering Committee used to set the health care cost growth target, and the methodologies for calculating performance against the target. It also contains the technical specifications for data reporting and collection.

The document is outlined as follows:

Section 1. Health Care Cost Growth Target and Methodology

Section 2. Methodology for Assessing Performance Against the Target

Appendix A. Insurer TME Data Specification

Appendix B. RI EOHHS TME Data Specification

Appendix C. Medicare Fee-For-Service TME Data Collection Process

Appendix D. Net Cost of Private Health Insurance Data Specifications

Appendix E. Rhode Island Total Population Statistics

Appendix F. Insurer Attestation

Attachment 1. Timeline for Reporting

Attachment 2. Total Health Care Expenditures Databook

Attachment 3. Medicare Expenditure and Enrollment Request Template

Attachment 4. Cost Growth Target Performance Submission Template

## I. Health Care Cost Growth Target Definition and Methodology

**Definition:** The health care cost growth target is the targeted annual per capita growth rate for Rhode Island’s total health care spending, expressed as the percentage growth from the prior year’s per capita spending. The health care cost growth target is set on a calendar year basis.

**Methodology:** Executive Order 19-03 sets the Target for 2019-2022 as 3.2%, which is equal to Rhode Island’s per capita potential gross state product (PGSP). The formula for the forecasted growth in per capita PGSP is as follows:

$$\text{expected growth in national labor force productivity} + \text{expected growth in the state civilian labor force} + \text{expected national inflation} - \text{expected state population growth}$$

As directed by Executive Order 19-03, during 2022, the methodology of the Target is to be reassessed and maintained, or replaced with a new target for 2023 and beyond. To assist in the reassessment, the sources for each of the components of the PGSP formula as calculated for Executive Order 19-03 are included below in Table 1.

*Table 1. Sources for PGSP Formula*

| Components  | Source  |
|---|---|
| <b>Expected growth in national labor force productivity</b> | <p>The source is the most recently published <u>Congressional Budget Office Budget and Economic Outlook Report</u>.<sup>1</sup> Included within the report is a table of Key Inputs in the CBO’s Projections of Real Potential GDP that includes the potential labor force productivity projected average annual growth from 2023–2028 (Page 13, Table 2 of the August 2018 report).</p> <p>In general, the figure used to calculate PGSP should be the value that is forecast for five through 10 years into the future.</p> |
| <b>Expected growth in the state civilian labor force</b>    | <p>The source is the Rhode Island Office of Management and Budget purchased forecast from IHS Economics or another vendor.<sup>2</sup></p> <p>Specifically, the figure can be found on the employment tab of the IHS Economics US Regional Service September 2018 Long</p>  |

<sup>1</sup> As of July 22, 2019, the Congressional Budget Office published its Budget and Economic Outlook Reports here: [www.cbo.gov/about/products/major-recurring-reports#1](http://www.cbo.gov/about/products/major-recurring-reports#1).

<sup>2</sup> The IHS Economics Forecast purchased by the RI Office of Management and Budget was supplied to Bailit Health and Cory King by Matt McCabe in the Office of Regulatory Reform. Mr. McCabe reported in an email on October 3, 2018 that these data are also used at the Revenue Estimating Conference.

|   |   |
|---|---|
|   | Term workbook. Labor Force statistics are in row 65. In this case, the figure is the average growth in the Labor Force from the first quarter of 2023 through the fourth quarter of 2028.   |
| <b>Expected national inflation</b>      | <p>The source is the most recently published <u>Congressional Budget Office Budget and Economic Outlook Report</u>.<sup>3</sup> Included within the report is a table of CBO's Economic Projections for Calendar Years 2018 to 2028 (Page 5, Table 1 of the August 2018 report).</p> <p>In general, the figure used to calculate PGSP should be the value of the "PCE price index" percentage change from year-to-year that is forecast for five through 10 years into the future.</p>  |
| <b>Expected state population growth</b> | <p>The source is the Rhode Island Population Projections Summary Tables from the Division of Statewide Planning.</p> <p>In general, the figure used to calculate PGSP should be the percentage change from year-to-year that is forecast for five through 10 years into the future.</p> <p>In this case, because the Division of Statewide Planning provides forecasts in five-year bands, the calculation used the figures that were as close to five through 10 years into the future. Specifically, the figure used to calculate PGSP is the annualized growth rate between 2025 and 2030.</p> |

For the development of the initial Target, the time period of 2023-2028 was consistent with the desired future forecast period of five to 10 years into the future (which is a common future period used in economic modeling). When reviewing the Target in 2022, should PGSP remain the target, a commensurate future time period for calculating the Target will need to be used.

Using the sources listed above, the value calculated to establish the Target (PGSP) in Executive Order 19-03 is presented in Table 2.

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<sup>3</sup> As of July 22, 2019 the Congressional Budget Office published its Budget and Economic Outlook Reports here: [www.cbo.gov/about/products/major-recurring-reports#1](http://www.cbo.gov/about/products/major-recurring-reports#1).

Table 2. PGSP Calculation

| Components  | Value from Sources Listed in Table 1 | Formula     |
|---|--------------------------------------|-------------|
| Expected growth in national labor force productivity      | 1.4%                                 | A           |
| Expected growth in the state civilian labor force         | 0.0%                                 | B           |
| Expected national inflation                               | 2.0%                                 | C           |
| Nominal potential gross state product                     | 3.4%                                 | $D = A+B+C$ |
| Expected state population growth                          | 0.2%                                 | E           |
| Potential per capita gross state product for Rhode Island | 3.2%                                 | $D-E$       |

## II. Methodology for Assessing Performance Against the Health Care Cost Growth Target

Executive Order 19-03 requires OHIC and EOHHS to report annually during the fourth quarter on performance relative to the Target during the prior calendar year at the state, health insurance market, individual payer, and accountable care organization level for entities of a sufficient size, using clinical risk-adjustment methodologies. To do so, OHIC will lead the state efforts to perform a series of data collection activities and calculations. This chapter contains the methodology for measuring the growth in health care spending at each level, including which data are necessary to collect and which calculations need to be performed.<sup>4</sup> This chapter is organized as follows:

- A. Definitions of Key Terms
- B. Methodology for Measuring Total Health Care Expenditures (THCE)
- C. Data Sources for THCE
- D. Public Reporting of Cost Growth Target Performance
- E. Timeline for Measuring and Reporting the Health Care Cost Growth Target

### A. Definitions of Key Terms

- **Accountable Care Organization (ACO):** A provider organization contracted with one or more payers and held accountable for the quality health care, outcomes and total cost of care of an attributed commercial or Medicare population.
- **Accountable Entity (AE):** Rhode Island Medicaid's version of an Accountable Care Organization. A provider organization contracted with one or more Medicaid insurers and held accountable for the quality health care, outcomes and total cost of care of an attributed Medicaid population. AEs are certified by EOHHS.
- **Allowed Amount:** The amount the payer paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Health Care Expenditures.
- **Insurer:** A private health insurance company that offers commercial insurance and may also administer benefits for self-insured employers, Medicare Advantage and/or are Medicaid managed care organization (MCO) products.

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<sup>4</sup> These methodologies and reporting specifications are derived, in part, from materials published by the Massachusetts Center for Health Information and Analysis, and the Delaware Health Care Commission. These materials have been edited from previously published materials to reflect the Rhode Island model.

- **Market:** The highest levels of categorization of the health insurance market. For example, Medicare and Medicare Advantage are collectively referred to as the “Medicare Market.” Medicaid Fee-for-Service and Medicaid MCO Managed Care are collectively referred to as the “Medicaid Market.” Individual, self-insured, small and large group markets and student health insurance are collectively referred to as the “Commercial Market.”
- **Measurement Year:** The Measurement Year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.
- **Net Cost of Private Health Insurance (NCPHI):** Measures the costs to Rhode Island residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers’ costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market and insurer levels. NCPHI is not reported at the Accountable Care Organization level.
- **Payer:** A term used to refer collectively to both insurers and public programs that are submitting data to OHIC.
- **Payer Recoveries:** Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in insurer total medical expense (TME) reporting.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.<sup>5</sup> The computation of TCHE at the statewide, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).<sup>6</sup>
- **Provider:** A term referring to a medical group, individual provider, Accountable Care Organization or similar entities for which TME data are collected from payers in support of the Cost Growth Target.

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<sup>5</sup> Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service feeds, distribution service fees, patient care management programs, etc.)

<sup>6</sup> CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.



- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare Fee-For-Service, Medicaid Fee-for-Service and similar programs.
- **Total Health Care Expenditures (THCE):** The total medical expense incurred by Rhode Island residents for all health care services for all payers reporting to OHIC, plus the insurers' Net Cost of Private Health Insurance. Defining specifications of THCE are included in Section B of this chapter.
- **Total Health Care Expenditures Per Capita:** Total Health Care Expenditures (as defined above) divided by Rhode Island's total state population. The annual change in THCE per capita is compared to the Target at the state, market and insurer levels. THCE will not be reported at the ACO/AE level.<sup>7</sup>
- **Total Medical Expense (TME):** The total medical expense incurred by Rhode Island residents for all health care services by all payers reporting to OHIC. TME is reported net of Pharmacy Rebates at the state, market and payer level, but not at the provider level. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, etc.) and at the ACO/AE level whenever possible. More detailed TME reporting specifications are contained in the Appendices of this manual.

## B. Methodology for Measuring Total Health Care Expenditures

To assess changes in the amount of health care spending, OHIC will need to calculate THCE annually. OHIC should measure THCE on an aggregate dollar and per capita basis. The aggregate dollar figure will be for informational purposes only. The change in THCE on a per capita basis will be used to assess performance against the Target.

*THCE (in aggregate) =*

*Commercial TME + Medicare Advantage TME + Medicare FFS TME +  
Medicaid MCO TME + RI EOHHS FFS TME + Insurer NCPHI*

*THCE (per capita) =*

$$\frac{\left( \text{Commercial TME} + \text{Medicare Advantage TME} + \text{Medicare FFS TME} + \right. \\ \left. \text{Medicaid MCO TME} + \text{Medicaid FFS TME} + \text{Insurer NCPHI} \right)}{\text{Rhode Island Population}}$$

The percentage change in THCE per capita between the Measurement Year and the prior calendar year will be used to assess performance against the Target applicable to the specific measurement year.

<sup>7</sup> NCPHI, a component of THCE, is not reportable at the ACO level. Therefore, THCE is not reported at the ACO/AE level.

The defining specifications of THCE are:

- It represents spending by or on behalf of Rhode Island residents in and out-of-state. Spending associated with people who live out-of-state is excluded.
- It includes spending on health care services/benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).
- Vision and dental spending are generally excluded except in instances where vision and dental services are covered as a health insurance benefit or are a covered benefit under Medicaid and Medicare.
- It represents the total Allowed Amount, which is inclusive both of amounts covered by payers and out-of-pocket spending associated with insured medical expenditures (e.g., copays and deductibles). In order to avoid double counting expenditures, health care premium payments are not included. Also, due to the lack of available data, other out-of-pocket expenditures recorded by providers, but not by insurers, are not included (e.g., spending for medical care by uninsured residents of Rhode Island, privately purchased health care services).
- It includes all insurance market segments, including public and private payers listed in this manual, fully and self-insured, and student insurance with the following limited exceptions: US Department of Veterans Affairs, the TRICARE program and health spending by the Rhode Island Department of Corrections that is not otherwise covered by Medicaid.
- The administrative costs and underwriting gain/loss of insurers, referred to as the NCPHI, are included (see Section C of this chapter for more detail).
- TME data is only collected from a payer when it is the primary payer for a claim. The primary payer will report on the allowed amount. If the secondary payer of the claim were to report, it would cause double counting of a portion of the Allowed Amount by the primary payer.
- TME is adjusted to account for any pharmacy rebates received by the payer, by subtracting the rebates (revenue) from the payer's total medical expense.
- Provider resources applied in the delivery of care for uninsured Rhode Islanders should not be included in calculations of health care spending because they are technically not "spending" as defined herein. Future reporting on spending relative to the Target

should, however, indicate that while these resource applications are not captured in the measurement of total health care spending, they may be significant for certain providers.

### C. Data Sources for THCE

Data for THCE comes from several sources. Attachment 2 is a template OHIC will use to input data from these sources. Attachment 2 contains illustrative data that will need to be replaced with the actual data OHIC receives. Insurers will need to report TME for all lines of business and, in some instances, insurers will need to report data for the State to calculate the NCPHI. Other data sources include the Centers for Medicare and Medicaid Services (CMS) and EOHHS. Table 3, below, outlines the data source by THCE category and the location of the detailed specification or collection process within this manual.

Table 3. Data Sources for THCE

| THCE Category  | Data Source   | Location of Data Specification/Collection Process in Manual |
|--|---|---|
| <b>Expenditures from Insurers</b>  |   |   |
| <b>Insurer full claim (comprehensive coverage with no carve-outs)</b>  | TME reported by insurers  | Appendix A  |
| <b>Insurer partial claim (coverage with carve-outs, such as pharmacy) calculated values</b>  | TME reported by insurers, with actuarial estimates produced by insurers | Appendix A  |
| <b>Insurer non-claim payments</b>  | TME reported by insurers  | Appendix A  |
| <b>Prescription drug spending for Medicare Advantage, for market level reporting only. (Insurer-level reporting data source is within TME reported by insurers.)<sup>8</sup></b> | CMS   | Appendix C  |

<sup>8</sup> CMS will provide OHIC with allowed amounts for Medicare FFS beneficiaries with stand-alone prescription drug plans (PDP) and for Medicare managed care beneficiaries with stand-alone PDP and Medicare Advantage Prescription Drug Plans (MAPD) in aggregate. CMS should be the source of pharmacy expenditure data for market-level spending as it will include all stand-alone PDP spending, even by insurers not reporting TME to OHIC and insurers specifically excluding stand-alone PDP

| <b>Expenditures from Public Programs</b>                       |   |            |
|--|---|------------|
| <b>EOHHS claim (Medicaid FFS and other) calculated values</b>  | EOHHS   | Appendix B |
| <b>Medicare FFS claim (Parts A, B and D) calculated values</b> | CMS   | Appendix C |
| <b>Net Cost of Private Health Insurance</b>                    |   |            |
| <b>Insurer NCPHI</b>   | Calculated from regulatory reports submitted by the insurers or obtained through public sources | Appendix D |
| <b>Pharmacy Rebates</b>  |   |            |
| <b>Insurers</b>  | Pharmacy rebate data filing by insurers   | Appendix A |
| <b>Medicaid Program</b>  | Pharmacy rebate data filing by EOHHS  | Appendix G |
| <b>Population Statistics</b>                                   |   |            |
| <b>Population of Rhode Island</b>                              | Rhode Island Division of Statewide Planning   | Appendix E |

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spending from TME. For reporting at the insurer-level, each individual insurer should be the source of spending. However, stand-alone PDP spending has been excluded from reporting at the insurer-level because doing so would compromise the integrity of the spending calculations.

## *Insurer TME Data*

TME represents all payments for medical expenses for the Rhode Island resident population and will be reported by payers for all members (including fully and self-insured members). TME is adjusted (reduced) to account for pharmacy rebates.

Annually, OHIC will need to direct applicable insurers to submit TME data using the specifications outlined in **Appendix A** and the templated provided as **Attachment 4**. Specifications for public programs to submit their TME are included in **Appendices B-C**, with the Medicare template provided as **Attachment 3**. Table 4, below, lists which insurers should report for their commercial, Medicare Advantage and Medicaid/CHIP managed care markets.<sup>9</sup>

*Table 4. Insurers Requested to Report TME Data by Market*

| <b>Insurer</b>                        | <b>Commercial Fully and Self-Insured</b> | <b>Medicare Advantage</b> | <b>Medicaid Managed Care</b> |
|---------------------------------------|--|---------------------------|------------------------------|
| <b>Blue Cross Blue Shield of RI</b>   | X  | X                         |                              |
| <b>Neighborhood Health Plan of RI</b> | X  |                           | X                            |
| <b>Tufts Health Plan</b>              | X  |                           | X                            |
| <b>UnitedHealthcare</b>               | X  | X                         | X                            |

The TME data include claims and non-claims payments<sup>10</sup> for a single calendar year. Payers should submit these data based on Allowed Amounts. Payers are expected to adjust expenditure data for a reasonable and appropriate estimate of unpaid claims liability (i.e., incurred but not reported (IBNR) or incurred by not paid (IBNP)) using actuarially sound principles. TME spending is only reported by a payer when it is the primary insurer on the claim, as secondary coverage expenditures would generally double count a portion of the allowed amount by the primary insurer.

In some circumstances, insurers are only able to report claims payments for a subset of medical services due to benefit design in which the contracting employer may “carve out” some services, such as pharmacy or behavioral health. In other carve-out instances, however, insurers are unable to obtain the payment information and do not hold the insurance risk for the carved-out services. Thus, insurers will need to report this type of TME data separately in the partial-

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<sup>9</sup> This table represents the largest insurers in the Rhode Island insurance market as of April 2019. Because the market may change, this table may need to be updated over time.

<sup>10</sup> Claims payments and payments to providers associated with a health care claim. Non-claims payments are payments to providers that are not associated with a claim and include capitation payments, pay-for-performance bonuses, risk settlements, care management payments, etc.

claim category (see **Appendix A** for more information). To estimate the full TME amount for partial claim population, the insurer will need to make actuarial adjustments based on the reported partial-claim TME data. An actuarial adjustment will allow OHIC to estimate the full spending amount without having to collect data from carve-out vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book-of-business average pharmacy spending per-member, per-month (PMPM) for the same year, calculated on members who had primary coverage, applied to all member months for which the carve-out applied. Before this adjustment is made, OHIC should discuss appropriate methodologies with the insurers, recognizing there is no standard approach to performing this estimate, but that actuarially sound principles should be used.

**Appendix A** includes instructions for insurers to submit pharmacy rebate data so that OHIC can subtract pharmacy rebates from THCE and TME at the market and insurer levels. Payers will need to proportionally allocate total pharmacy rebates by line of business to Rhode Island resident members, unless rebates can be directly associated to a specific line of business.

#### *NCPHI Data*

The final component of THCE is NCPHI. This element captures the costs to Rhode Island residents associated with the administration activities and underwriting gain/loss of insurers. It is the difference between health premiums earned and benefits incurred. It includes all categories of administrative expenditures, net additions to reserves, rate credits and dividends, and profits and losses.

OHIC will need to calculate NCPHI for all Rhode Island residents whose insurers are submitting data to OHIC, using data obtained from insurers and other public sources. NCPHI should exclude out-of-state residents covered under Rhode Island-based insurance plans. The methodology that OHIC will need to follow in order to calculate NCPHI is listed in **Appendix D**.

### **D. Public Reporting of Cost Growth Target Performance**

To publicly report on performance against the Target and as directed in Executive Order 19-03, OHIC will report at the statewide level, with several “drill-down” analyses. The following specifications propose the minimal levels of public reporting that OHIC should undertake. The type of public reporting of performance relative to the Target will likely evolve over time. Therefore, this manual should be updated as the public reporting processes change.

Table 5 outlines the minimum level at which OHIC should publicly report performance. When reporting TME, OHIC should report on a per-member per year (PMPY) basis, which calculates the average amount of spending per member for a particular market segment.

Table 5. *Levels at Which Public Reporting of Performance Against Target Should Occur*

| Level                    | THCE   | TME/NCPHI   |
|--------------------------|--|---|
| <b>State level</b>       | Aggregate and per capita<br>Compare per capita rate of change against Target | Report TME and NCPHI components                                     |
| <b>Commercial market</b> | Aggregate and PMPY<br>Compare PMPY rate of change against Target             | Report TME and NCPHI components                                     |
| <b>Medicare market</b>   | Aggregate and PMPY<br>Compare PMPY rate of change against Target             | Report TME only<br>(NCPHI not applicable)                           |
| <b>Medicaid market</b>   | Aggregate and PMPY   | Report TME only<br>(NCPHI not applicable)                           |
| <b>Insurer Level</b>     | PMPY<br>Compare PMPY rate of change against Target                           | Report TME and NCPHI components                                     |
| <b>ACO/AE Level</b>      | N/A  | Report TME only, PMPY<br>Compare PMPY rate of change against Target |

Reporting should be done using both text and graphics that are engaging to the reader and easy to understand. For an example of how reporting can be done, please see Attachment 5 – Center for Health Information and Analysis’ Performance of the Massachusetts Health Care System Annual Report.

## *Reporting TME by Service Category*

In the event that the State is unable to secure sufficient funding to support ongoing APCD analysis, as recommended in the Health Care Cost Trends Project Steering Committee's Data Use Strategy<sup>11</sup>, the TME data specifications for payers, outlined below, will facilitate payer data reporting by major service category. By analyzing service category spending, OHIC will be able to understand the scale of changes in individual service categories and the share of TME spending changes that are attributable to each service category.

A goal with the collection of TME data is to obtain summary-level payer data segmented into a manageable number of distinct service categories that all payers can consistently and accurately report. However, in reality, there may be limitations on some payers' ability to report data at the desired service category level. Therefore, if the State is unable to secure sufficient funding to support ongoing APCD analysis, OHIC should collect service category data at the highest level. Ideally, payers would utilize a standardized list of claims codes by service category, but to create a list requires a time-intensive effort on behalf of the State to define the categories or an agreement to use a pre-defined list, like the one developed by the Health Care Cost Institute.<sup>12</sup> Payers would also have to undergo a resource-intensive effort to configure reports in the standardized format.

The highest-level individual service categories for the submission and subsequent reporting of TME data from all payers consists of the following common service categories:

- Hospital Inpatient
- Hospital Outpatient
- Professional Physician (Primary Care)
- Professional Physician (Specialty Care)
- Professional Other
- Long-Term Care
- Retail Pharmacy<sup>13</sup>
- Pharmacy Rebates
- Other

More information on what specific types of services are included in each of the respective service categories is provided within the payer technical specification appendices. For the duration that these categories are not defined with specific codes, OHIC should acknowledge when analyzing and reporting these data publicly that there may be some limitations in

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<sup>11</sup> Final Rhode Island Cost Trends Project Data Use Strategy Recommendations, May 17, 2019.

<sup>12</sup> See [www.healthcostinstitute.org/images/pdfs/HCCI\\_2017\\_Methodology\\_public\\_v20.pdf](http://www.healthcostinstitute.org/images/pdfs/HCCI_2017_Methodology_public_v20.pdf)

<sup>13</sup> Insurers that have both Medicare Advantage and stand-alone PDP lines of business must exclude their stand-alone PDP data from their TME submission. Stand-alone PDP expenditure data will be obtained from CMS.



consistent interpretation across payers. In future years, OHIC should consider facilitating a process whereby a pre-established claims code-level definition could be used consistently across payers. At that time, additional, more detailed categories of services could be added, such as lab and imaging, for example, to deepen OHIC analysis capabilities.

#### *Reporting TME by ACO/AE and Members Unattributed to an ACO/AE*

OHIC will request that insurers submit TME data at the ACO/AE level, by line of business, by applying an attribution methodology that will assign members to an ACO/AE as follows:

1. Medicaid:
  - a. Medicaid members who were attributed during the measurement year to an AE using the attribution rules established by EOHHS.
  - b. Medicaid members not attributed to an AE (to be reported in aggregate).
2. Commercial and Medicare:
  - a. Commercial and Medicare Advantage members who were attributed during the measurement year, pursuant to a contract between the insurer and ACO for financial or quality performance assessment purposes. Members can be attributed monthly, quarterly, annually, or at another frequency, so long as the attribution timing is consistent with the insurer contract.
  - b. Commercial and Medicare Advantage members not attributed to an ACO (to be reported in aggregate).

The data will be reported at the ACO/AE level by line of business for each payer, which is outlined in the TME specification in **Appendix A**. Data must include all TME for all attributed members, including when care was provided by providers outside of or not affiliated with the respective ACO/AE. Furthermore, for OHIC to calculate market performance, insurers must report spending in aggregate for members not attributed to an ACO/AE and in aggregate for ACOs/AEs that fall below the minimum threshold (see below). The details of insurer attribution to an ACO/AE is included in the TME specification in **Appendix A**.

In order to publicly report on Rhode Island ACO/AE performance, the Health Care Cost Trends Steering Committee made recommendations on the minimum number of attributed members required to report provider performance. Annually, OHIC should publicly report, by line of business, on the clinical risk-adjusted TME for ACOs/AEs that meet the following criteria:

- A minimum of 120,000 attributed commercial or Medicaid member months with an individual payer for one or more lines of business
- A minimum of 60,000 attributed Medicare member months with an individual payer for one or more lines of business.

OHIC should require insurers to submit non-adjusted TME data. OHIC will adjust TME based on member clinical risk using insurer-reported clinical risk-adjustment scores. Because these tools used to create the clinical risk adjustment scores will likely vary from insurer to insurer, it is not possible to compare or combine clinical risk-adjusted TME data across insurers for public reporting purposes.

Given the small size of many Rhode Island ACOs/AEs, prior to reporting data in 2020, the State will develop guidelines for when to signify provider deviation from Target as statistically meaningful (i.e., not at high risk of influence by random variation) in consultation with the Steering Committee or a successor stakeholder body. This might entail additional analysis of the APCD to develop performance confidence interval bands. These confidence interval bands should be applied to provider reporting.

## **E. Timeline for Measuring and Reporting the Cost Growth Target**

Executive Order 19-03 calls for OHIC to publish THCE statistics in the fourth quarter of each calendar year following the respective reporting/data year. For example, CY 2019 performance will be reported in the fourth quarter of CY 2020. To the extent practical, OHIC should publish the THCE statistics close to the beginning of the fourth quarter. OHIC should anticipate that the first year of reporting may involve a longer timeline and higher start-up costs due to the time required to process questions, develop reporting templates, create data exhibits and resolve unanticipated issues.

Since CY 2019 is the first year for which performance against the Target will be measured, OHIC will need to collect CY 2017 and CY 2018 THCE data to serve as the initial baseline comparison for CY 2019 results. Therefore, OHIC will first need to collect CYs 2017-2018 data in the third and fourth quarters of CY 2019. This step will enable OHIC and payers to work through and resolve issues with the data collection process, file formats and other technical or logistical issues in advance of the following year's process of reporting CY 2019 performance against the Target.

Due to the timing of ACO/AE settlements, insurers will need to annually submit two years' worth of data: (1) the performance year data (which is the calendar year immediately preceding the year in which TME data are reported) which will contain insurer estimates of ACO/AE settlements, and (2) the TME data for the calendar year prior to the performance year which will be resubmitted to reflect final settlements that had to be estimated during prior year reporting. The annual timeline for measuring and reporting on the Cost Growth Target is included as **Attachment 1**.

## Appendix A

### Insurer TME Data Specification

This insurer TME data specification provides technical details to assist insurers in reporting and filing data to enable OHIC to calculate TME. This appendix can serve as a stand-alone document to serve as a guide for TME data reporting.

OHIC will annually request TME data file(s) with dates of service during the prior calendar year, and any other past years upon request. Files will contain different record types, including:

- Header, summary data, payer comments
- TME by ACOs/AEs

This insurer TME data specification appendix is directly based on Massachusetts' and Delaware's TME data collection specification, modified to meet the needs of Rhode Island. However, the file format is as close to identical to the Massachusetts' and Delaware's as possible to aid insurers that operate in one or both of the other markets. OHIC may periodically update and revise these data specifications in subsequent versions.

#### *TME File Submission Instructions and Schedule*

TME file layouts for insurers are included in this appendix. Further file submission instructions will be available on OHIC's website. Insurers will submit flat files of their TME data.<sup>14</sup> The fields are variable in length and relative to position; therefore, they need to be separated by an asterisk (\*). Insurers will submit this information on an annual basis.

Insurers will submit TME data on the following schedule:

| Insurers' TME Filing Schedule |   |
|-------------------------------|---|
| Date                          | Files Due                               |
| October 1, 2019               | CY 2017 Final and 2018 Estimated TME    |
| August 3, 2020                | CY 2018 Final and CY 2019 Estimated TME |
| August 2, 2021                | CY 2019 Final and CY 2020 Estimated TME |
| August 1, 2022                | CY 2020 Final and CY 2021 Estimated TME |
| August 1, 2023                | CY 2021 Final and CY 2022 Estimated TME |

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<sup>14</sup> A flat file is a file without structure or formatting.

## *TME Data Submission*

Insurers must report TME data based on allowed amounts (i.e., the amount the insurer paid plus any member cost sharing).

Insurers must include only information pertaining to members:

- who are residents of Rhode Island, and
- for which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer).

Insurers must attribute members to an ACO according to the following categorization:

1. Medicaid:
  - a. Medicaid members who were attributed during the measurement year to an AE using the attribution rules established by EOHHS.<sup>15</sup>
  - b. Medicaid members not attributed to an AE (reported in aggregate).
2. Commercial and Medicare:
  - a. Commercial and Medicare Advantage members who were attributed during the measurement year, pursuant to a contract between the insurer and ACO for financial or quality performance assessment purposes. Members can be attributed monthly, quarterly, annually, or at another frequency, so long as the attribution timing is consistent with the insurer contract.
  - b. Commercial and Medicare Advantage members not attributed to an ACO (reported in aggregate).

Insurers must report three categories of data, by Insurance Category Code:

1. TME data applicable to ACOs/AEs for which the insurer has a minimum number of lives attributed to the ACO/AE during the reporting period as follows:
  - A minimum of 120,000 attributed commercial or Medicaid member months with an individual payer for one or more lines of business
  - A minimum of 60,000 attributed Medicare member months with an individual payer for one or more lines of business.
2. TME data applicable to ACOs/AEs with fewer numbers of attributed members than required, reported in aggregate.
3. Member spending not attributable to an ACO/AE, reported in aggregate.

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<sup>15</sup> See page 4 of Rhode Island Accountable Entity Program, Attachment L1: Accountable Entity Total Cost of Care Requirements – Program Year Two Requirements, Rhode Island Executive Office of Health and Human Services, December 11, 2018.

Insurers must include all allowed amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Rhode Island, and regardless of the situs of the member's plan.<sup>16</sup>

The data reported for each ACO/AE must include all TME for all attributed members for each month a member was attributed, so long as the member was a resident at the time of attribution, even when care was provided by providers outside of or not affiliated with the respective ACO/AE entity.

#### *Claims Run-Out Period Specifications*

Insurers shall allow for a claims run-out period of at least 120 days after December 31 of the performance year. Payers should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category based on commonly accepted actuarial principles and will be required to attest that they are reasonable and appropriate.

#### *ACO / AE Organization IDs*

The following ACOs/AEs are to be reported on using the identification number for TME reporting listed in Table 6. This list of ACOs/AEs may be updated from time to time as the ACO/AE market changes. The intent is for payers to report on all ACOs and certified AEs in Rhode Island.

Table 6. ACO/AE Organization Identification Numbers

| ACO/AE Organization                            | Identification Number for TME Reporting |
|--|---|
| <b>Blackstone Valley Community Health Care</b> | 101                                     |
| <b>Coastal Medical</b>                         | 102                                     |
| <b>Integra Community Care Network</b>          | 103                                     |
| <b>Integrated Healthcare Partners</b>          | 104                                     |
| <b>Lifespan</b>                                | 105                                     |
| <b>Providence Community Health Centers</b>     | 106                                     |
| <b>Prospect CharterCARE</b>                    | 107                                     |
| <b>Members Not Attributed to an ACO/AE</b>     | 108                                     |

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<sup>16</sup> If the insurer plays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.

|   |     |
|---|-----|
| <b>Members Attributed to ACO/AEs with Fewer Attributed Members Than Required for ACO/AE-Level Reporting</b> | 109 |
|---|-----|

### *TME Data File Layouts and Field Definitions*

Each item below represents a column in the TME Data File Layout that insurers will use to submit TME data to OHIC using an Excel template provided by OHIC. There are two TME data files that insurers must submit: a header record file and an ACO file. A pharmacy rebate data file will also be submitted. Each is described below in more detail:

#### **Header Record File**

**Record Type:** Must have “HD-TME” inputted to indicate that this is a header record.

**Insurer Org ID:** The OHIC assigned organization ID for the insurer submitting the file.<sup>17</sup>

| Insurer                        | Organizational ID |
|--------------------------------|-------------------|
| Blue Cross Blue Shield of RI   | 201               |
| Neighborhood Health Plan of RI | 202               |
| Tufts Health Plan              | 203               |
| UnitedHealthcare               | 204               |

**National Plan ID:** National plan identification number. This element is not required at this time, but may be required for future filings.

**Period Beginning and Ending Dates:** The beginning period of time represented by the reported data. These dates should always be January 1 and December 31, respectively, unless an insurer newly enters or exits the market during other parts of the year. All reporting is based on the date of service related to the TME data.

**Clinical Risk Adjustment Tool:** The clinical risk adjustment tool, software or product used to calculate the clinical risk score required in the TME file.

**Clinical Risk Adjustment Version:** The version number of the clinical risk adjustment tool used to calculate the clinical risk adjustment score required in the TME file.

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<sup>17</sup> This table may need to be updated from time to time as the insurer market in Rhode Island changes.

**Comments:** Insurers may use this field to provide any additional information or describe any data caveats for the TME submission.

**Reserved:** There are data elements labeled as “Reserved” in the header record file layout. These are fields that are reserved for possible future use.

### *ACO / AE Record File*

The ACO/AE record file will be the source of the insurer’s expenditure data that will be used by OHIC/EOHHS to compute THCE. Insurers will report their permissible claims and non-claims payments in this file.

**Record Type:** Must have “AR” inputted to indicate that this is an ACO/AE record.

**ACO/AE OrgID:** The OHIC OrgID of the ACO/AE. Note, for ACOs/AEs that do not meet the minimum threshold for an insurer, by line of business, TME data for those members is to be reported in aggregate and labeled “all other.” For TME data for members who are unattributed to an ACO/AE, their data are to be reported in aggregate as “unattributed.”

**Insurance Category Code:** A number that indicates the insurance category that is being reported. All data reported by Insurance Category Code should be mutually exclusive. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for large providers for which the insurer is able to collect information on all direct medical claims and any claims paid by a delegated entity should be reported in the “Full Claims” category. Commercial data that does not include all medical and subcarrier claims should be reported in the “Partial Claims”, and an actuarial adjustment should be made to those claims to allow for them to be comparable to full claims. Such an adjustment must use actuarially sound principles and be reviewed with OHIC before the adjustment is made.<sup>18</sup> The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve out vendors, such as PBMs or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied. Insurers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold. For insurers reporting in the “Other” category, insurers should describe in the Comments field (HD006) what is included in the “Other” category.

| Insurance Category Code | Definition |
|-------------------------|------------|
|-------------------------|------------|

<sup>18</sup> Email [Cory.King@ohic.ri.gov](mailto:Cory.King@ohic.ri.gov) with the insurer’s proposed approach for making an actuarial sound adjustment to its Partial Claims.

|   |  |
|---|--|
| 1 | Medicare & Medicare Advantage                                |
| 2 | Medicaid & Medicaid Managed Care (MCO)                       |
| 3 | Commercial – Full Claims                                     |
| 4 | Commercial – Partial Claims, Adjusted                        |
| 5 | Omitted <sup>19</sup>  |
| 6 | Medicare and Medicaid Dual Eligibles, ages 65 years and over |
| 7 | Medicare and Medicaid Dual Eligibles, ages 21 years–64 years |
| 8 | Other  |

**Member Months (annual):** The number of members participating in a plan over the specified period of time expressed in months of membership.

**Clinical Risk Score:** A value that measures a member’s illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must disclose the health status adjustment tool and version number and calibration settings in the header record.

Insurers must submit a clinical risk score that represents all members being reported by Insurance Category Code and the three categories articulated under *TME Data Submission*. Insurers are permitted to use a clinical risk adjustment tool and software of their own choosing, but must disclose the tool (e.g., ACG, DxCG, etc.) and the version in the comment fields of the TME data files. TME data are not to be adjusted. For the purposes of reporting, OHIC will make the necessary adjustments to TME data based on the insurer-submitted clinical risk score. It will do so by weighting the member months according to the value of the clinical risk score (i.e., the higher risk, the fewer member months) and will use the adjusted member months value to calculate the percentage change in TME year-over-year.

Where possible, payers must apply the following parameters in completing the clinical risk adjustment:

- The clinical risk adjustment tool used should correspond to the insurance category reported (i.e., Medicare, Medicaid, Commercial).
- The clinical risk scores values should reflect only of Rhode Island residents within the Insurance Category Code.

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<sup>19</sup> Omitted in Rhode Island in order to keep specification as similar to Massachusetts as possible for the benefit of national insurers.



- The weighted average of all clinical risk scores within each Insurance Category Code submitted by an insurer should value 1.
- Insurers must use concurrent modeling.
- The clinical risk adjustment tool must be all-encounter diagnosis-based (no cost inputs) and output total medical and pharmacy costs with no truncation.

If an insurer changes its clinical risk adjustment method and software (including version updates), it must re-report at least one prior year of TME data using the modified clinical risk adjustment method in order to ensure comparability between years.

**Claims: Hospital Inpatient:** The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.

**Claims: Hospital Outpatient:** The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

**Claims: Professional Physician, Primary Care:** The TME paid to physicians or physician group practices generated from claims. Includes services provided by any care provider defined by the health plan as a PCP (including doctors of medicine or osteopathy in family medicine, internal medicine, general medicine or pediatric medicine, nurse practitioners, physicians assistants or others not explicitly listed here). The one exception is OB/GYNs may not be considered a PCP for this purpose.

**Claims: Professional Physician, Specialty:** The TME paid to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined by the health plan as a PCP.

**Claims: Professional Other:** The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists and chiropractors.

**Claims: Retail Pharmacy:** The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. Medicare Advantage insurers that offer stand-alone PDPs should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

**Claims: Long-Term Care:** The TME paid from claims to health care providers for skilled or custodial nursing facility services, home health care services, home- and community-based services, hospice and private duty/shift nursing services.

**Claims: Other:** All TME paid from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the insurer is unable to classify the service. However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category.

**Non-Claims: Incentive Programs:** All payments made to providers for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.

**Non-Claims: Capitation and Risk Settlements:** All payments made to providers as a reconciliation of payments made (risk settlements) and payments made not on the basis of claims (capitated amount). Amounts reported as capitation and risk settlement should not include any incentive or performance bonuses.

**Non-Claims: Care Management:** All payments made to providers for providing care management, utilization review, and discharge planning.

**Non-Claims: Recovery:** All payments recouped during the performance year as the result of a prior review, audit or investigation, regardless of the time period of the initial payment. This field should be reported as a negative number, and be as of June 30<sup>th</sup> of the year in which data are reported. Only report data in this column that is not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).

**Non-Claims: Other:** All other payments made pursuant to the insurer's contract with a provider that were not made on the basis of a claim for health care benefits/services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

## Pharmacy Rebate Record File

The pharmacy rebate file will be the source of the insurer's pharmacy rebate and will be used by OHIC/EOHHS to compute THCE and TME. Insurers will report their rebate data in this file.

**Record Type:** Must have "Rx" inputted to indicate that this is a pharmacy rebate record.

**Insurance Category Code:** A number that indicates the insurance category that pharmacy rebates are being reported on. Use the applicable Insurance Category Code as defined previously in the ACO/AE Record File (not all Insurance Category Codes may be applicable to pharmacy rebates).

**Pharmacy Rebates:** The estimated value of rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the period beginning date through end date from the ACO/AE file, excluding manufacturer-provided fair market value bona fide service fees.<sup>20</sup> This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.). Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which reporting will be done. If insurers are unable to report rebates specifically for Rhode Island residents, insurers should report estimated rebates attributed to Rhode Island resident members in a proportion equal to the proportion of pharmacy spending for Rhode Island resident members compared to pharmacy spending for total members, by line of business. For example, if Rhode Island resident commercial member spending represent 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported. If the insurer is unable to identify the percentage of pharmacy spending for Rhode Island resident members, then the insurer should calculate the pharmacy rebates attributable to Rhode Island resident members using percent of membership.

**Member Months (annual):** The number of members participating in a plan over the specified period of time expressed in months of membership.

## *Market Enrollment File*

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<sup>20</sup> Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

The market enrollment file will be the source of the insurer's member months by market in that it will be used by OHIC/EOHHS to compute NCPHI. Insurers will report their member months by market in this file.

**Record Type:** Must have "ME" inputted to indicate that this is the market enrollment file.

**Market Enrollment:** The number of members participating in a plan categorized by the insurer as individual, large group, small group, self-insured and student markets. Insurers should report member months (see definition below) by market enrollment category listed below.

| Market Enrollment Category Code | Definition     |
|---------------------------------|----------------|
| 1                               | Individual     |
| 2                               | Large group    |
| 3                               | Small group    |
| 4                               | Self-insured   |
| 5                               | Student market |

**Member Months (annual):** The number of members participating in a plan over the specified period of time expressed in months of membership.

| RECORD<br>TYPE | ELEMENT | DATA<br>ELEMENT<br>NAME       | DATE<br>ACTIVE<br>(VERSION) | TYPE        | FORMAT                       | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE  |
|----------------|---------|-------------------------------|-----------------------------|-------------|------------------------------|--------|---------------------|---|
| HD-TME         | HD001   | Record type                   | 1/1/2019                    | Text        | HD                           | 2      |                     | This must have HD reported here. Indicates the beginning of the Header Record.  |
| HD-TME         | HD002   | Insurer Org ID                | 1/1/2019                    | Integer     | ###                          | 3      | Yes                 | This is the Insurer OrgID.  |
| HD-TME         | HD003   | National Plan ID              | 1/1/2019                    | Text        |                              | 30     | No                  | Unique identifier as outlined by CMS for Plans.   |
| HD-TME         | HD004   | Period beginning date         | 1/1/2019                    | Date period | MMDDYYYY<br>Or<br>MM/DD/YYYY | 10     | Yes                 | This is the start date period of the reported period in the submission file (based on date of service).                               |
| HD-TME         | HD005   | Period ending date            | 1/1/2019                    | Date period | MMDDYYYY<br>Or<br>MM/DD/YYYY | 10     | Yes                 | This is the end date period of the reported period in the submission file (based on date of service).;                                |
| HD-TME         | HD006   | Insurer Comments              | 1/1/2019                    | Text        | Free Text<br>Comments        | N/A    | No                  | Insurer's comments on TME data.   |
| HD-TME         | HD007   | Clinical Risk Adjustment Tool | 1/1/2019                    | Text        | Text                         | 80     | Yes                 | The clinical risk adjustment tool, software or product used to calculate the clinical risk adjustment score required in the TME file. |

| RECORD<br>TYPE | ELEMENT | DATA<br>ELEMENT<br>NAME                | DATE<br>ACTIVE<br>(VERSION) | TYPE    | FORMAT | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE  |
|----------------|---------|--|-----------------------------|---------|--------|--------|---------------------|---|
| HD-TME         | HD008   | Clinical Risk<br>Adjustment<br>Version | 1/1/2019                    | Text    | Text   | 20     | Yes                 | The version number of the clinical risk adjustment tool used to calculate the clinical risk adjustment score required in the TME file.  |
| ACO_AE<br>TME  | AR001   | TME Record<br>Type ID                  | 1/1/2019                    | Text    | Text   | 2      | Yes                 | This must have AR reported here. Indicates the beginning of the ACO/AE-based TME record.  |
| ACO_AE<br>TME  | AR002   | ACO/AE Org ID                          | 1/1/2019                    | Integer | ###    | 3      | Yes                 | OHIC/EOHHS assigned ORG ID for ACOs/AEs<br><br>For aggregation of all members unattributed to a an ACO, use 108.<br><br>For aggregation of ACOs/AEs that are below the minimum threshold use 109. |
| ACO_AE<br>TME  | AR003   | Insurance Category<br>Code             | 1/1/2019                    | Integer | #      | 1      | Yes                 | Indicates the insurance category that is being reported:  |

| RECORD<br>TYPE | ELEMENT | DATA<br>ELEMENT<br>NAME | DATE<br>ACTIVE<br>(VERSION) | TYPE    | FORMAT | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE  |
|----------------|---------|-------------------------|-----------------------------|---------|--------|--------|---------------------|---|
|                |         |                         |                             |         |        |        |                     | <p>1 = Medicare &amp; Medicare Advantage</p> <p>2 = Medicaid &amp; Medicaid MCOs</p> <p>3 = Commercial: Full-Claim</p> <p>4 = Commercial: Partial-Adjusted</p> <p>6 = Medicare and Medicaid Dual-Eligibles, 65 and over</p> <p>7 = Medicare and Medicaid Dual-Eligibles, 21–64</p> <p>8 = Other</p> <p>Value must be an integer between '1' and '4' or between '6' and '8'.</p> |
| ACO_AE<br>TME  | AR004   | Member Months           | 1/1/2019                    | Integer | #####  | 9      | Yes                 | The number of members attributed to the “ACO/AE Org ID” over a specified  |

| RECORD<br>TYPE | ELEMENT | DATA<br>ELEMENT<br>NAME           | DATE<br>ACTIVE<br>(VERSION) | TYPE   | FORMAT   | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE  |
|----------------|---------|-----------------------------------|-----------------------------|--------|----------|--------|---------------------|---|
|                |         |                                   |                             |        |          |        |                     | period of time expressed in months of membership.   |
| ACO_AE<br>TME  | AR005   | Clinical Risk<br>Adjustment Score | 1/1/2019                    | Number | ##.##    | 6      | Yes                 | A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.<br><br>No negative values.<br>Number must be between '0.0' and '10'. |
| ACO_AE<br>TME  | AR006   | Claims: Hospital<br>Inpatient     | 1/1/2019                    | Money  | #####.## | 12     | Yes                 | Total allowed claims for hospital inpatient medical expenses.<br><br>No negative values.  |
| ACO_AE<br>TME  | AR007   | Claims: Hospital<br>Outpatient    | 1/1/2019                    | Money  | #####.## | 12     | Yes                 | Total allowed claims for hospital outpatient medical expenses.<br><br>No negative values.   |
| ACO_AE<br>TME  | AR008   | Claims:<br>Professional           | 1/1/2019                    | Money  | #####.## | 12     | Yes                 | Total allowed claims for professional primary care physician medical expenses.  |



| RECORD<br>TYPE | ELEMENT | DATA<br>ELEMENT<br>NAME                            | DATE<br>ACTIVE<br>(VERSION) | TYPE  | FORMAT   | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE   |
|----------------|---------|--|-----------------------------|-------|----------|--------|---------------------|--|
|                |         | Physician,<br>Primary Care                         |                             |       |          |        |                     | No negative values.  |
| ACO_AE<br>TME  | AR009   | Claims:<br>Professional<br>Physician,<br>Specialty | 1/1/2019                    | Money | #####.## | 12     | Yes                 | Total allowed claims for<br>professional specialty<br>physician medical expenses.<br><br>No negative values. |
| ACO_AE<br>TME  | AR010   | Claims:<br>Professional<br>Other                   | 1/1/2019                    | Money | #####.## | 12     | Yes                 | Total allowed claims for<br>other professional services<br>medical expenses.<br><br>No negative values.      |
| ACO_AE<br>TME  | AR011   | Claims: Retail<br>Pharmacy                         | 1/1/2019                    | Money | #####.## | 12     | Yes                 | Total allowed claims for<br>retail pharmacy medical<br>expenses.<br><br>No negative values.                  |
| ACO_AE<br>TME  | AR012   | Claims: Long-Term<br>Care                          | 1/1/2019                    | Money | #####.## | 12     | Yes                 | Total allowed claims for all<br>long-term care expenses.<br><br>No negative values.                          |
| ACO_AE<br>TME  | AR013   | Claims: Other                                      | 1/1/2019                    | Money | #####.## | 12     | Yes                 | Total allowed claims for all<br>other medical expenses.<br><br>No negative values.                           |

| RECORD<br>TYPE | ELEMENT | DATA<br>ELEMENT<br>NAME                           | DATE<br>ACTIVE<br>(VERSION) | TYPE  | FORMAT   | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE   |
|----------------|---------|---|-----------------------------|-------|----------|--------|---------------------|--|
| ACO_AE<br>TME  | AR014   | Non-Claims:<br>Incentive Programs                 | 1/1/2019                    | Money | #####.## | 12     | Yes                 | Total payments made to<br>providers for achievement<br>of specific predefined goals.<br><br>No negative values.  |
| ACO_AE<br>TME  | AR015   | Non-Claims:<br>Capitation and<br>Risk Settlements | 1/1/2019                    | Money | #####.## | 12     | Yes                 | All payments made to<br>providers for risk<br>settlements and capitation.<br><br>No negative values.   |
| ACO_AE<br>TME  | AR016   | Non-Claims: Care<br>Management                    | 1/1/2019                    | Money | #####.## | 12     | Yes                 | All payments made to<br>providers for providing care<br>management, utilization<br>review, and discharge<br>planning.<br><br>No negative values.                                   |
| ACO_AE<br>TME  | AR017   | Non-Claims:<br>Recovery                           | 1/1/2019                    | Money | #####.## | 12     | Yes                 | All payments recouped<br>during the performance<br>year as the result of a prior<br>review, audit or<br>investigation, regardless of<br>the time period of the initial<br>payment. |

| RECORD<br>TYPE | ELEMENT | DATA<br>ELEMENT<br>NAME | DATE<br>ACTIVE<br>(VERSION) | TYPE    | FORMAT   | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE   |
|----------------|---------|-------------------------|-----------------------------|---------|----------|--------|---------------------|--|
|                |         |                         |                             |         |          |        |                     | Report as a negative number.   |
| ACO_AE<br>TME  | AR018   | Non-Claims: Other       | 1/1/2019                    | Money   | #####.## | 12     | Yes                 | All other payments made pursuant to the insurer's contract with a provider that were not made on the basis of a claim for health care benefits/services and that cannot be properly classified elsewhere.<br><br>No negative values. |
| RX Rebates     | RX001   | Record Type             | 1/1/2019                    | Text    | Text     | 2      | Yes                 | This must have RX reported here. Indicates the beginning of the Pharmacy Rebate file.  |
| RX Rebates     | RX002   | Insurance Category Code | 1/1/2019                    | Integer | #        | 1      | Yes                 | Indicates the insurance category that is being reported:<br><br>1 = Medicare & Medicare Advantage<br><br>2 = Medicaid & Medicaid MCOs<br><br>3 = Commercial: Full-Claim  |

| RECORD<br>TYPE    | ELEMENT | DATA<br>ELEMENT<br>NAME | DATE<br>ACTIVE<br>(VERSION) | TYPE    | FORMAT   | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE  |
|-------------------|---------|-------------------------|-----------------------------|---------|----------|--------|---------------------|---|
|                   |         |                         |                             |         |          |        |                     | 4 = Commercial: Partial-Adjusted<br><br>6 = Medicare and Medicaid Dual-Eligibles, 65 and over<br><br>7 = Medicare and Medicaid Dual-Eligibles, 21-64<br><br>8 = Other<br><br>Value must be an integer between '1' and '4' or between '6' and '8'. |
| RX Rebates        | RX0003  | Pharmacy Rebates        | 1/1/2019                    | Money   | #####.## | 15     | Yes                 | Total pharmacy rebates estimated for Rhode Island members.  |
| RX Rebates        | RX0004  | Member Months           | 1/1/2019                    | Integer | #####    | 9      | Yes                 | The number of members participating in a plan over a specified period of time expressed in months of membership.  |
| Market Enrollment | ME001   | Record Type             | 1/1/2019                    | Text    | Text     | 2      | Yes                 | This must have ME reported here. Indicates the beginning of the Market Enrollment file.   |

| RECORD<br>TYPE       | ELEMENT | DATA<br>ELEMENT<br>NAME            | DATE<br>ACTIVE<br>(VERSION) | TYPE    | FORMAT | LENGTH | CONTENT<br>REQUIRED | ELEMENT<br>SUBMISSION<br>GUIDELINE   |
|----------------------|---------|------------------------------------|-----------------------------|---------|--------|--------|---------------------|--|
| Market<br>Enrollment | ME002   | Market Enrollment<br>Category Code | 1/1/2019                    | Integer | #      | 1      | Yes                 | 1 = individual<br><br>2 = large group<br><br>3 = small group<br><br>4 = self-insured<br><br>5 = student market               |
| Market<br>Enrollment | ME003   | Member Months                      | 1/1/2019                    | Integer | #####  | 9      | Yes                 | The number of members<br>participating in market over<br>a specified period of time<br>expressed in months of<br>membership. |

## **File Submission Naming Conventions**

Data submissions should follow the following naming conventions:

### **Insurer Name\_TME\_YYYY\_Version.xls**

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

### **Below are examples of valid file names:**

TME\_2018\_01.xlsx or TME\_2018\_1.xlsx or TME\_2018.xlsx

### **Submitting Files to OHIC/EOHHS**

Electronic files are to be submitted to [Cory.King@ohic.ri.gov](mailto:Cory.King@ohic.ri.gov)

## **Appendix B**

### **EOHHS TME Data Specification**

**DRAFT 7-30-2019**

This EOHHS TME data specifications provides technical details to assist EOHHS in reporting and filing data to enable OHIC to calculate TME. This appendix can serve as a stand-alone document to serve as a guide for TME data reporting.

OHIC will annually request TME data files(s) from EOHHS with dates of service during the prior calendar year, and any other past years upon request. Files will contain different record types, including:

- Header, summary data, payer comments
- TME by AEs

EOHHS data submission is to include TME data on the following categories:

- FFS claims expenditures for enrollees in Rite Care, including any wrap-around or out of plan payments for dental services for children, developmental disability services and behavioral health services in excess of MCO coverage limits. Data should be submitted on an aid category code basis and / or MCO enrollment indicators.
- FFS claims expenditures for individuals not eligible for Rite Care or in the Rite Care “FFS waiting period.” Expenditures should include data on individuals excluded from Rite Care, data on Rite Care eligible individuals during their “FFS window” prior to enrollment in managed care. Data should be submitted on an aid category code group basis.
- Other EOHHS FFS claims expenditures not included in any of the aforementioned categories such as FFS expenditures for populations or programs that are paid with State-only general funds (e.g., RI Pharmaceutical Program for the Elderly, DOH Pharmacy Program, DEA Copay Program)
- EOHHS’ premium payments, capitation or lump sum payments to Rhode Island’s Program for All-Inclusive Care for the Elderly (PACE) organization(s). PACE payments are considered non-claims payments.
- EOHHS’s premium payments, capitation or lump sum payments to vendors for non-emergency medical transportation (NEMT). NEMT payments are considered non-claims payments. Data should be submitted on a line of business basis.
- EOHHS’s other non-claims expenditures, as applicable.
- Federal and state supplemental pharmacy rebate collections. There is a separate file to report EOHHS pharmacy rebate data. See below for more details.

EOHHS data submission should not include:

- Data related to Rhody Health Options as Medicaid is the payer of last resort. Data on this population will be reported through Medicare.
- Any expenditures made from or to EOHHS from or to Rite Care MCOs that are not considered claims (e.g., monthly capitation payments, maternity supplemental payments, net risk mitigation payments, net incentives/penalties)
- AE incentive payments made to the MCOs through MMIS.

OHIC may periodically update and revise these data specifications in subsequent versions of this implementation manual.

**Pharmacy Rebates:** The actual value of total federal and state supplemental rebates collected by EOHHS on behalf of the State Medicaid program (including rebates collected on behalf of the MCOs) which are provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding to the period beginning date through end date of the respective calendar year, excluding manufacturer-provided fair market value bona fide service fees.<sup>21</sup> This amount shall include rebate guarantee amounts and any additional rebate amounts. Total rebates should be reported without regard to how they are paid to EOHHS (e.g., through regulator aggregate payments, on a claims-by-claim basis, etc.).

The source of the Medicaid rebates is Allison Shartrand, Public Assistance Business Manager. ([Allison.Shartrand@ohhs.ri.gov](mailto:Allison.Shartrand@ohhs.ri.gov)). Medicaid rebates should be requested on a CY basis, and in aggregate for the FFS and MCO populations, separately.

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<sup>21</sup> Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.)



## Appendix C

### Medicare FFS TME Data Specification

OHIC will be able to receive TME and enrollment data from Medicare FFS annually by September 1 of the year following the measurement period (e.g., 2018 data will be available September 1, 2019). CMS believes that data will be at least 90% complete by September 1.

Specifically, CMS will share total program payments and cost sharing for the following services:

- Hospital inpatient
- Hospital outpatient
- Non-hospital outpatient
- Home health agency
- Hospice
- Skilled nursing facility
- Physician (primary care)
- Physician (specialty)
- Other professionals
- Durable medical equipment
- Other suppliers
- Part D<sup>22</sup>

These services are mapped to the TME reporting categories as follows:

| Medicare Service Categories | TME Service Mapping                   |
|-----------------------------|---------------------------------------|
| Hospital Inpatient          | Hospital Inpatient                    |
| Hospital Outpatient         | Hospital Outpatient                   |
| Non-Hospital Outpatient     | Other                                 |
| Home Health Agency          | Other                                 |
| Hospice                     | Long-Term Care                        |
| Skilled Nursing Facility    | Long-Term Care                        |
| Physician (Primary Care)    | Professional Physician (Primary Care) |

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<sup>22</sup> As part of the TME data received from CMS, CMS will be providing OHIC Part D data for individuals enrolled in FFS stand-alone PDPs as well as Medicare managed care enrollees in MAPD or MA-only plans.

|                            |   |
|----------------------------|---|
| Physician (Specialty Care) | Professional Physician (Specialty Care) |
| Other Professionals        | Other                                   |
| Durable Medical Equipment  | Other                                   |
| Other Suppliers            | Other                                   |
| Part D                     | Retail Pharmacy                         |

CMS will also share enrollment figures for Medicare Parts A, B and D broken out between managed care and FFS.

To receive Medicare FFS TME data from CMS, DHSS needs to make a formal request to CMS by emailing the attached Excel file (**Attachment 3**) to Stephanie Bartee, Acting Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.gov) and copying: [CMSProgramStatistics@cms.hhs.gov](mailto:CMSProgramStatistics@cms.hhs.gov). **Please note, CMS has specifically requested that Rhode Island staff (not a contractor) make the official request.**

CMS is willing to share the data with OHIC by September 1 if the data request is made by June 1.

## Appendix D

### NCPHI Data Specification

$$THCE = \frac{\text{Commercial TME} + \text{Medicare Advantage TME} + \text{Medicare FFS TME} + \text{Medicaid MCO TME} + \text{RI EOHHS FFS TME} + \text{Insurer NCPHI}}{\text{Rhode Island Population}}$$

#### NET COST OF PRIVATE HEALTH INSURANCE

This element captures the costs to Rhode Island residents associated with the administration of private health insurance. It is defined as the difference between health premiums earned and benefits incurred and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits or losses. **NCPHI is reported as a component of THCE at the State, market and insurer levels. NCPHI should not be reported at the provider level.**

Because of substantial differences among segments of the Rhode Island health insurance market, NCPHI will be calculated on a PMPM basis separately for the seven different market segments: (1) Individual Market; (2) Small Group, Fully Insured; (3) Large Group, Fully Insured; (4) Student; (5) Medicare Advantage; (6) Medicaid MCOs; and (7) Self-Insured. To derive the aggregate NCPHI, each segment's PMPM amount will then be multiplied by the Rhode Island resident market enrollment, in each segment, in member months as reported within the TME submission. The methodology and data sources for the calculation of NCPHI for each market segment are described below.

#### **Individual, Small Group, Fully Insured, Large Group, Fully Insured and Student Markets (collectively, the "commercial fully insured market")**

The federal commercial medical loss ratio (MLR) reports will be used to calculate NCPHI for the commercial fully insured market.<sup>23</sup> MLR reports need to be requested from insurers as part of their TME data submission due annually on August 1. Although these reports become publicly available in the fall, insurers will need to submit them August 1 in order to meet the reporting timeline. In an instance in which the MLR report submitted to OHIC on August 1 differs from the final submission an insurer makes to the federal Center for Consumer Information and Insurance Oversight, the insurer must notify OHIC in writing as soon as possible. The data elements that will be used in the calculation are detailed below:

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<sup>23</sup> Available at: [www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html](http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html). Last accessed April 16, 2019.

NCPHI =

*Premium as of March 31 (Part 1 Line 1.1) - [Total Incurred Claims as of March 31 (Part 1, Line 2.1) - Advance Payments of Cost Sharing Reductions (Part 2, Line 2.18)] - MLR Rebates Current Year (Part 3, Line 6.4)*

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months}}$$

### **Medicare Advantage**

The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners will be used to derive NCPHI of the Medicare Advantage market. The SHCE can be obtained from OHIC annually each April. The Medicare Advantage reporting combines stand-alone prescription drug plans (PDP) and the Medicare Advantage plans with Part D inclusion (MAPDs). Therefore, insurers that offer both PDP and MAPD will need to separately report health premiums earned, total incurred claims and members months for PDP and MAPD. The data elements that will be used in the calculation are detailed below.

NCPHI =

*Health Premiums Earned (Part 1, Line 1.1) - Total Incurred Claims (Part 1, Line 5.0)*

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months}}$$

### **Medicaid MCO Market**

The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners will be used to derive NCPHI of the Medicaid MCO Market. The SHCE can be obtained from OHIC annually each April. The data elements that will be used in the calculation should from column 10 "Government Business (Excluded by Statue)." The formula is included below:

NCPHI =

*Health Premiums Earned (Part 1, Line 1.1) - Total Incurred Claims (Part 1, Line 5.0)*

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months}}$$

### **Self-Insured Market**

The SHCE will be used to derive NCPHI of the self-insured market. The formula will be:

NCPHI =

*Income from fees of uninsured plans (Part 1, Line 12)*

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months}}$$

*Member Months*

The table below provides the columns associated with each line of business/market in the SHCE and the MLR reports.

| LINE OF BUSINESS/MARKET    | SHCE COLUMN | MLR COLUMN (PARTS 1 AND 2) | MLR COLUMN (PART 3) |
|----------------------------|-------------|----------------------------|---------------------|
| Individual                 | N/A         | 2                          | 4                   |
| Small Group, Fully Insured | N/A         | 7                          | 8                   |
| Large Group, Fully Insured | N/A         | 12                         | 12                  |
| Student                    | N/A         | 36                         | 36                  |
| Medicare Advantage and PDP | 12          | N/A                        | N/A                 |
| Medicaid MCO               | N/A         | N/A                        | N/A                 |
| Self-Insured               | 14          | N/A                        | N/A                 |

## Appendix E

### Rhode Island Total Population Statistics

The denominator of the THCE per capita calculation is the Rhode Island state population count for the respective reporting period. The source of the Rhode Island population value is the [US Census Bureau](#) estimates. The most recently available census figures, which will be a snapshot in time figures (not full-year estimates) for the measurement year, should be used as the “Rhode Island Population” figure in the THCE per capita formula listed below.

*THCE (per capita) =*

$$\frac{\left( \begin{array}{l} \text{Commercial TME} + \text{Medicare Advantage TME} + \text{Medicare FFS TME} + \\ \text{Medicaid MCO TME} + \text{Medicaid FFS TME} + \text{Insurer NCPHI} \end{array} \right)}{\text{Rhode Island Population}}$$

## Appendix F Insurer Attestation

### Attestation of the Accuracy and Completeness of Reported Data

**Instructions:** Please enter all requested information in the blank spaces provided below and have an authorized signatory sign the attestation. Insurers should submit one “Attestation of the Accuracy and Completeness of Reported Data” per performance period. Scanned copies of the signed attestations should be emailed to: [Cory.King@ohic.ri.gov](mailto:Cory.King@ohic.ri.gov)

**Insurer:** \_\_\_\_\_

**Performance Period Being Reported:** \_\_\_\_\_

Pursuant to Rhode Island’s establishment, monitoring and implementation of annual Health Care Cost Growth Target under Governor Raimondo’s Executive Order 19-03 and State-defined reporting guidelines, certain health insurers operating in the state of Rhode Island must annually submit certain data requested to calculate insurer and provider performance relative to Rhode Island’s Target.

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under any applicable state laws. Failure to sign this Attestation of the Accuracy and Completeness of Reported Data will result in OHIC non acceptance of the attached reports.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title